FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046425

Facility Name: Sullivan Health Care Center

Address: 11 Hawthorne Ln. (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4327 **Fax #** (217) 728-2263

IDPA ID Number: 371068286011

Date of Initial License for Current Owners: 12/01/1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	45,018	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,144	4,144	8
9	SNF/PED					9
10	ICF	13,716	7,608		21,324	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,716	7,608	4,144	25,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.57%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/03/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/30/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 4,144

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	124,351	9,438		133,789		133,789	5,546	139,335			1
2	Food Purchase		120,273		120,273		120,273	(7,331)	112,942			2
3	Housekeeping	78,437	13,963		92,400		92,400	23	92,423			3
4	Laundry	32,766	12,912		45,678		45,678	552	46,230			4
5	Heat and Other Utilities			114,696	114,696		114,696	603	115,299			5
6	Maintenance	34,174	29,218	14,267	77,659		77,659	5,616	83,275			6
7	Other (specify):* mgmt alloc of benefits							992	992			7
8	**TOTAL General Services**	269,728	185,804	128,963	584,495		584,495	6,001	590,496			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	871,471	150,458	1,051	1,022,980		1,022,980	15,448	1,038,428			10
10a	Therapy		42	393,699	393,741		393,741	5	393,746			10a
11	Activities	23,898	816		24,714		24,714	5	24,719			11
12	Social Services	26,116	13		26,129		26,129		26,129			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* mgmt alloc of benefits							4,385	4,385			15
16	**TOTAL Health Care and Programs**	921,485	151,329	406,750	1,479,564		1,479,564	19,843	1,499,407			16
	C. General Administration											
17	Administrative	96,891		229,000	325,891		325,891	(160,950)	164,941			17
18	Directors Fees											18
19	Professional Services			9,396	9,396		9,396	23,170	32,566			19
20	Dues, Fees, Subscriptions & Promotions			6,951	6,951		6,951	2,909	9,860			20
21	Clerical & General Office Expenses	22,430	4,835	13,964	41,229		41,229	57,918	99,147			21
22	Employee Benefits & Payroll Taxes			226,343	226,343		226,343		226,343			22
23	Inservice Training & Education			399	399		399	743	1,142			23
24	Travel and Seminar			518	518		518	2,086	2,604			24
25	Other Admin. Staff Transportation			3,623	3,623		3,623	5,889	9,512			25
26	Insurance-Prop.Liab.Malpractice			91,116	91,116		91,116	1,461	92,577			26
27	Other (specify):* mgmt alloc of benefits							16,880	16,880			27
28	**TOTAL General Administration**	119,321	4,835	581,310	705,466		705,466	(49,894)	655,572			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,310,534	341,968	1,117,023	2,769,525		2,769,525	(24,050)	2,745,475			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sullivan Health Care Center #0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			128,443	128,443		128,443	8,266	136,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			200,779	200,779		200,779	23,827	224,606			32
33	Real Estate Taxes			(3,388)	(3,388)		(3,388)	18,361	14,973			33
34	Rent-Facility & Grounds							2,870	2,870			34
35	Rent-Equipment & Vehicles			13,423	13,423		13,423	(452)	12,971			35
36	Other (specify):*											36
37	**TOTAL Ownership**			339,257	339,257		339,257	52,872	392,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,286		81,286		81,286		81,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,528	67,528		67,528		67,528			42
43	Other (specify):* Nonallowable Costs			23,012	23,012		23,012	(23,012)				43
44	**TOTAL Special Cost Centers**		81,286	90,540	171,826		171,826	(23,012)	148,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,310,534	423,254	1,546,820	3,280,608		3,280,608	5,810	3,286,418			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,062)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(218)	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,102)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,910)	43		18
19	Entertainment				19
20	Contributions	(950)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(242)	43		24
25	Fund Raising, Advertising and Promotional	(3,689)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch. 5A	4,610			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,574)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,384		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,384		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,810		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center
Provider #: 0046425
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Lab - Part A	(4344)	43
X-Ray Part A	(207)	43
Special Event	(1506)	43
Offset Vending income	(74)	2
Offset Meal Income	(7259)	2
To record Real Estate Taxes	18,000	33
Total	$ 4,610	

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center

ID# 0046425

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Health Care Center # 0046425 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	5,546	0	0	0	0	0	0	0	0	0	5,546	1
2	Food Purchase	0	2	0	0	0	0	0	0	0	0	0	2	2
3	Housekeeping	0	23	0	0	0	0	0	0	0	0	0	23	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	503	0	100	0	0	0	0	0	0	0	603	5
6	Maintenance	0	3,465	0	2,151	0	0	0	0	0	0	0	5,616	6
7	Other (specify):*	0	992	0	0	0	0	0	0	0	0	0	992	7
8	**TOTAL General Services**	0	10,531	0	2,251	0	0	0	0	0	0	0	12,782	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	12,184	0	3,264	0	0	0	0	0	0	0	15,448	10
10a	Therapy	0	5	0	0	0	0	0	0	0	0	0	5	10a
11	Activities	0	5	0	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,177	0	3,208	0	0	0	0	0	0	0	4,385	15
16	**TOTAL Health Care and Programs**	0	13,371	0	6,472	0	0	0	0	0	0	0	19,843	16
	C. General Administration													
17	Administrative	0	(150,950)	0	(10,000)	0	0	0	0	0	0	0	(160,950)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,291	0	10,879	0	0	0	0	0	0	0	23,170	19
20	Fees, Subscriptions & Promotions	0	547	0	2,362	0	0	0	0	0	0	0	2,909	20
21	Clerical & General Office Expenses	0	0	42,047	15,871	0	0	0	0	0	0	0	57,918	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	701	42	0	0	0	0	0	0	0	743	23
24	Travel and Seminar	0	0	1,489	597	0	0	0	0	0	0	0	2,086	24
25	Other Admin. Staff Transportation	0	0	2,861	3,028	0	0	0	0	0	0	0	5,889	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,001	460	0	0	0	0	0	0	0	1,461	26
27	Other (specify):*	0	0	11,543	5,337	0	0	0	0	0	0	0	16,880	27
28	**TOTAL General Administration**	0	(138,112)	59,642	28,576	0	0	0	0	0	0	0	(49,894)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(114,210)	59,642	37,299	0	0	0	0	0	0	0	(17,269)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Health Care Center # 0046425 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(218)	0	4,957	3,527	0	0	0	0	0	0	0	8,266	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	5,665	18,173	0	0	0	0	0	0	0	23,827	32
33	Real Estate Taxes	0	0	368	(7)	0	0	0	0	0	0	0	361	33
34	Rent-Facility & Grounds	0	0	2,870	0	0	0	0	0	0	0	0	2,870	34
35	Rent-Equipment & Vehicles	0	0	100	0	0	0	0	0	0	0	0	100	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(229)	0	13,960	21,693	0	0	0	0	0	0	0	35,424	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(16,955)	0	0	0	0	0	0	0	0	0	0	(16,955)	43
44	**TOTAL Special Cost Centers**	(16,955)	0	0	0	0	0	0	0	0	0	0	(16,955)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,184)	(114,210)	73,602	58,992	0	0	0	0	0	0	0	1,200	45

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100.00	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 5,546	$ 5,546	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	2	2	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	503	503	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,465	3,465	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	992	992	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	12,184	12,184	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	5	5	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	5	5	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,177	1,177	10
11	V	17	Administrative	219,000	Petersen Health Care, Inc.	100.00%	68,050	(150,950)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	12,291	12,291	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	547	547	13
14	Total			$ 219,000			$ 104,790	$ * (114,210)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 42,047	$ 42,047	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	701	701	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,489	1,489	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,861	2,861	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,001	1,001	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,543	11,543	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,957	4,957	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,665	5,665	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	368	368	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	2,870	2,870	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	100	100	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 73,602	$ * 73,602	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Petersen Health Care II, Inc.	0.00%	$ 100	$ 100	15
16	V	6	Maintenance		Petersen Health Care II, Inc.	0.00%	2,151	2,151	16
17	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	0.00%	3,264	3,264	17
18	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	3,208	3,208	18
19	V	19	Professional Services		Petersen Health Care II, Inc.	0.00%	10,879	10,879	19
20	V	20	Dues, Fees, Subs & Promos		Petersen Health Care II, Inc.	0.00%	2,362	2,362	20
21	V	21	Clerical & General Office		Petersen Health Care II, Inc.	0.00%	15,871	15,871	21
22	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	42	42	22
23	V	24	Travel and Seminar		Petersen Health Care II, Inc.	0.00%	597	597	23
24	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	0.00%	3,028	3,028	24
25	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	460	460	25
26	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	5,337	5,337	26
27	V	30	Depreciation		Petersen Health Care II, Inc.	0.00%	3,527	3,527	27
28	V	32	Interest		Petersen Health Care II, Inc.	0.00%	18,173	18,173	28
29	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	(7)	(7)	29
30	V	17	Administrative	10,000	Petersen Health Care II, Inc.	0.00%		(10,000)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,000			$ 68,992	$ * 58,992	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center
Provider #0046425
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Casey Health Care Center	Casey, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
El Paso Health Care Center	El Paso, IL	
Flora Health Care Center	Flora, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sheldon Health Care Center	Sheldon, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Tuscola Health Care Center	Tuscola, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Kewanee Courtyard Estates	Kewanee, IL	
Kewanee Courtyard Village	Kewanee, IL	
Monmouth Courtyard Estates	Monmouth, IL	
Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	1,024,939	1	2.50	Salary	$ 68,050	L17,C8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 68,050		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Sullivan Health Care Center
Provider #0046425
12/31/2004

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Peteresen Health Care, Inc.
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	25,468	$ 5,546	1
2	2	Food	Patient Days	409,056	18	33		25,468	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		25,468	23	3
4	5	Utilities	Patient Days	409,056	18	8,082		25,468	503	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	25,468	3,465	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		25,468	992	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	25,468	12,184	7
8	10A	Therapy	Patient Days	409,056	18	75		25,468	5	8
9	11	Activities	Patient Days	409,056	18	86		25,468	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		25,468	1,177	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	25,468	68,050	11
12	19	Professional Services	Patient Days	409,056	18	197,418		25,468	12,291	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		25,468	547	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	25,468	42,047	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		25,468	701	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		25,468	1,489	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		25,468	2,861	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		25,468	1,001	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		25,468	11,543	19
20	30	Depreciation	Patient Days	409,056	18	79,620		25,468	4,957	20
21	32	Interest	Patient Days	409,056	18	90,987		25,468	5,665	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		25,468	368	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		25,468	2,870	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		25,468	100	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 178,392	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care II, Inc.
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	115,099	5	$ 451	$	25,468	$ 100	1
2	6	Maintenance	Patient Days	115,099	5	9,723		25,468	2,151	2
3	10	Nursing and Medical Records	Patient Days	115,099	5	14,750	14,750	25,468	3,264	3
4	15	Mgmt. Allocation of Benefits	Patient Days	115,099	5	14,497		25,468	3,208	4
5	19	Professional Services	Patient Days	115,099	5	49,169		25,468	10,879	5
6	20	Dues, Fees, Subs & Promos	Patient Days	115,099	5	10,675		25,468	2,362	6
7	21	Clerical & General Office	Patient Days	115,099	5	71,727	24,541	25,468	15,871	7
8	23	Inservice Training & Education	Patient Days	115,099	5	190		25,468	42	8
9	24	Travel and Seminar	Patient Days	115,099	5	2,696		25,468	597	9
10	25	Other Admin. Staff Transport.	Patient Days	115,099	5	13,686		25,468	3,028	10
11	26	Insurance-Prop.Liab.Mal.	Patient Days	115,099	5	2,077		25,468	460	11
12	27	Mgmt. Allocation of Benefits	Patient Days	115,099	5	24,119		25,468	5,337	12
13	30	Depreciation	Patient Days	115,099	5	15,940		25,468	3,527	13
14	32	Interest	Patient Days	115,099	5	82,129		25,468	18,173	14
15	33	Real Estate Taxes	Patient Days	115,099	5	(33)		25,468	(7)	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 311,796	$ 39,291		$ 68,992	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ford Credit		X	Note	$518.90	10/22/03	$ 31,116	$ 23,337	10/22/08	0	$ 0	1
2	U.S. Bank		X	Mortgage	$40,714 +int	12/10/04	3,420,000	3,420,000	12/11	0.0699	0	2
3	Associated Bank		X	Mortgage	$19,705.00	11/20/03	2,250,000	0	12/04	Varies	186,470	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,223.90		$ 5,701,116	$ 3,443,337			$ 186,470	9
	B. Non-Facility Related*											
10								Home Office Allocation			23,838	10
11								Interest Income			(11)	11
12								Amortization of Loan Costs			14,309	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 38,136	14
15	TOTALS (line 9+line14)						$ 5,701,116	$ 3,443,337			$ 224,606	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 41,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 14,612	2
3. Under or (over) accrual (line 2 minus line 1).		$ (26,388)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Allocated from home office TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ 361	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 14,973	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003	14,612	12

2003 tax bill is only for 3 months
(365 days / 120 days) X $14,612 = $44,420 use $41,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sullivan Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691 -8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-11-400-004	PT NE1/4 SE1/4; 5.77A M/L	$ 14,612.00	$ 14,612.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 14,612.00	$ 14,612.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	334,095	2003	$ 100,000	1
2					2
3	TOTALS	334,095		$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	123		2003	1975	$ 1,560,545	$ 40,014	39	$ 40,014	$ (0)	$ 60,021	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2004	4,808	98	39	62	(36)	62	9
10	Fire Alarms			2004	1,524	5	39	20	15	20	10
11	Doors			2004	3,067	230	39	39	(191)	39	11
12	Smoke Alarms			2004	1,227	66	39	16	(50)	16	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,571,171	$ 40,413		$ 40,150	$ (263)	$ 60,158	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 568,545	$ 81,221	$ 81,221	$ (0)	7	$ 121,832	71
72	Current Year Purchases	8,834	587	631	44	7	631	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,484	8,484			74
75	TOTALS	$ 577,379	$ 81,808	$ 90,336	$ 8,528		$ 122,463	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	General	2003 Ford	2003	$ 31,116	$ 6,223	$ 6,223	$ 0	5	$ 9,335	76
77										77
78										78
79										79
80	TOTALS			$ 31,116	$ 6,223	$ 6,223	$ 0		$ 9,335	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,279,666	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 136,709	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,265	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 191,956	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				2,870			6
7	TOTAL				$ 2,870 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 12,971 Description: See Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center
Provider #0046425
12/31/2004

Schedule 14A

XII. Rental Equipment
Line 16

Type of Equipment	Cost
Home Office Allocation	100
Special Mattresses	7200
Oxygen Tanks	875
Dish Machine	365
Copy Machines	4431
	$ 12,971

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	13,853	$ 207,789	$	13,853	$ 207,789	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		9,463	141,948		9,463	141,948	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3 & C2	hrs		2,826	42,393	42	2,826	42,435	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				47,426		47,426	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L39, C2					33,860		33,860	13
14	TOTAL			$	26,142	$ 392,130	$ 81,328	26,142	$ 473,458	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center
Provider #: 0046425
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,899,710	$ 1,899,710	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	517,665	517,665	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,302	3,302	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,420,677	$ 2,420,677	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	1,566,877	1,571,171	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	612,789	608,495	16
17	Accumulated Depreciation (book methods)	(183,836)	(191,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposit	5,844	5,844	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,101,674	$ 2,093,554	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,522,351	$ 4,514,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 498,090	$ 498,090	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,682	56,682	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,000	41,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	64,188	64,188	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 659,960	$ 659,960	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,337	23,337	39
40	Mortgage Payable	3,420,000	3,420,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,443,337	$ 3,443,337	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,103,297	$ 4,103,297	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 419,054	$ 410,934	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,522,351	$ 4,514,231	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Sullivan Health Care Center
Provider # 0046425
12/31/2004

Schedule 17A

Line 36. Other Current Liabilities

	Operating	After Consolidation
Accrued Vacation	48,661	48,661
401-K Withholding	2,085	2,085
Federal Unemployment Tax	471	471
Accrued Sales Tax	405	405
Accrued Interest	10,619	10,619
Accrued Insurance - General	4,852	4,852
Accrued Insurance - W/C	(3,221)	(3,221)
Intercompany - Petersen Health Care	316	316
Total	**64,188**	**64,188**

See Accountants' Compilation Report

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 214,481	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 214,481	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	204,573	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 204,573	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 419,054	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,498,842	1
2	Discounts and Allowances for all Levels	172,216	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,671,058	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	655,751	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 655,751	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,785	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,473	20
21	Other Medical Services	4,770	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 151,028	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Meals	7,259	28
28a	Vending	74	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,333	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,485,181	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	584,495	31
32	Health Care	1,479,564	32
33	General Administration	705,466	33
	B. Capital Expense		
34	Ownership	339,257	34
	C. Ancillary Expense		
35	Special Cost Centers	104,298	35
36	Provider Participation Fee	67,528	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,280,608	40
41	**Income before Income Taxes (line 30 minus line 40)****	204,573	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 204,573	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
Entity is a cash basis tax payer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 52,818	$ 25.39	1
2	Assistant Director of Nursing	2,075	2,088	25,859	12.38	2
3	Registered Nurses	5,906	6,190	145,877	23.57	3
4	Licensed Practical Nurses	10,767	11,604	176,275	15.19	4
5	Nurse Aides & Orderlies	34,525	37,951	393,647	10.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,833	1,896	22,500	11.87	8
9	Activity Director	2,076	2,108	23,898	11.34	9
10	Activity Assistants					10
11	Social Service Workers	2,167	2,167	26,116	12.05	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,739	14.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,451	12,074	94,612	7.84	15
16	Dishwashers					16
17	Maintenance Workers	2,593	2,593	34,174	13.18	17
18	Housekeepers	9,792	9,958	78,437	7.88	18
19	Laundry	4,307	4,447	32,766	7.37	19
20	Administrator	2,080	2,080	96,891	46.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,059	2,083	22,430	10.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,953	2,038	20,166	9.89	31
32	Other Health Ca Care Plan Coordin	1,892	1,985	34,329	17.29	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,636	105,422	$ 1,310,534 *	$ 12.43	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	12,000	L09, C3	36
37	Medical Records Consultant	2	80	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	971	L10, C3	39
40	Physical Therapy Consultant	11	1,569	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	$ 14,620		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert G. Wilson	Administrator	0	$ 96,891
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,891

B. Administrative - Other

Description	Amount
Management Fees (eliminated)	$ 229,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 229,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Bush & Snyder Associates	Legal	196
Robert W. McQuellon	Accounting	2,668
Altschuler, Melvoin, & Glasser	Accounting	3,800
Greg Wilson	Computer	198
ADP	Computer	678
AdminaStar Federal	Computer	119
IVANS	Computer	417
LTC Solutions, Inc.	Computer	1,320
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,396

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,530
Unemployment Compensation Insurance	27,120
FICA Taxes	94,911
Employee Health Insurance	50,757
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	6,402
401-K Matching	623
TOTAL (agree to Schedule V, line 22, col.8)	$ 226,343

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,877
Advertising: Employee Recruitment	2,179
Health Care Worker Background Check	
(Indicate # of checks performed 52)	622
IL. Nursing Home Administrators Ass.	100
Rotary Club	1,025
Dues & Subscriptions	70
Licenses & Permits	78
Home Office Allocation	2,909
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,860

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	343
Home Office Allocation	2,086
Seminar Expense	175
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,604

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sullivan Health Care Center
Provider #: 0046425
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,396
Allocated from Management Company	
Legal	2,078
Other	21,092
Total (agree to Schedule V, line 19, column 8)	32,566

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9	N/A												
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sullivan Health Care Center # 0046425 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,998** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,528**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,259**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		124,351	9,438	0	133,789	0	133,789	5,546	139,335
2. Food Purchase		0	120,273	0	120,273	0	120,273	-7,331	112,942
3. Housekeeping		78,437	13,963	0	92,400	0	92,400	23	92,423
4. Laundry		32,766	12,912	0	45,678	0	45,678	552	46,230
5. Heat and Other Utilities		0	0	114,696	114,696	0	114,696	603	115,299
6. Maintenance		34,174	29,218	14,267	77,659	0	77,659	5,616	83,275
7. Other (specify)*		0	0	0	0	0	0	992	992
8. Total General Services		269,728	185,804	128,963	584,495	0	584,495	6,001	590,496
9. Medical Director		0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records		871,471	150,458	1,051	1,022,980	0	1,022,980	15,448	1,038,428
10a. Therapy		0	42	393,699	393,741	0	393,741	5	393,746
11. Activities		23,898	816	0	24,714	0	24,714	5	24,719
12. Social Services		26,116	13	0	26,129	0	26,129	0	26,129
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	4,385	4,385
16. Total Health Care & Programs		921,485	151,329	406,750	1,479,564	0	1,479,564	19,843	1,499,407
17. Administrative		96,891	0	229,000	325,891	0	325,891	-160,950	164,941
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	9,396	9,396	0	9,396	23,170	32,566
20. Fees, Subscriptions & Promotion		0	0	6,951	6,951	0	6,951	2,909	9,860
21. Clerical & General Office		22,430	4,835	13,964	41,229	0	41,229	57,918	99,147
22. Employee Benefits & Payroll		0	0	226,343	226,343	0	226,343	0	226,343
23. Inservice Training & Education		0	0	399	399	0	399	743	1,142
24. Travel and Seminar		0	0	518	518	0	518	2,086	2,604
25. Other Admin. Staff Trans		0	0	3,623	3,623	0	3,623	5,889	9,512
26. Insurance-Prop.Liab.Malpractice		0	0	91,116	91,116	0	91,116	1,461	92,577
27. Other (specify)*		0	0	0	0	0	0	16,880	16,880
28. Total General Adminis		119,321	4,835	581,310	705,466	0	705,466	-49,894	655,572
29. Total General Administrative		1,310,534	341,968	1,117,023	2,769,525	0	2,769,525	-24,050	2,745,475
30. Depreciation		0	0	128,443	128,443	0	128,443	8,266	136,709
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	200,779	200,779	0	200,779	23,827	224,606
33. Real Estate		0	0	-3,388	-3,388	0	-3,388	18,361	14,973
34. Rent - Facility & Grounds		0	0	0	0	0	0	2,870	2,870
35. Rent - Equipment & Vehicles		0	0	13,423	13,423	0	13,423	-452	12,971
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	339,257	339,257	0	339,257	52,872	392,129
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	81,286	0	81,286	0	81,286	0	81,286
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	67,528	67,528	0	67,528	0	67,528
43. Other (specify):*		0	0	23,012	23,012	0	23,012	-23,012	0
44. Total Special Cost Ce		0	81,286	90,540	171,826	0	171,826	-23,012	148,814
45. Grand Total		1,310,534	423,254	1,546,820	3,280,608	0	3,280,608	5,810	3,286,418

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,899,710	1,899,710
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	517,665	517,665
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	3,302	3,302
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,420,677	2,420,677
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	1,666,877	1,671,171
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	612,789	608,495
17. Accumulated Depreciation (book methods)	-183,836	-191,956
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	5,844	5,844
24. Total Long-Term Assets	2,101,674	2,093,554
25. Total Assets	4,522,351	4,514,231
CURRENT LIABILITIES		
26. Accounts Payable	498,090	498,090
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	56,682	56,682
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	41,000	41,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	64,188	64,188
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	659,960	659,960
LONG TERM LIABILITES		
39.Long-Term Notes Payable	23,337	23,337
40.Mortgage Payable	3,420,000	3,420,000
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,443,337	3,443,337
46.Total Liabilities	4,103,297	4,103,297
47.Total Equity	419,054	410,934
48.Total Liabilities and Equity	4,522,351	4,514,231

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,498,842
2. Discounts and Allowances for all Levels	172,216
Subtotal - Inpatient Care	2,671,058
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	655,751
7. Oxygen	0
Subtotal - Anciliary Revenue	655,751
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	141,785
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	4,473
21. Other Medical Services	4,770
22. Laundry	0
Subtotal - Other Operating Revenue	151,028
24. Contributions	0
25. Interest and Other Investments Income	11
Subtotal - Non-Operating Revenue	11
27. Other Revenue (specify):	7,333
28. Other Revenue (specify):	0
Subtotal - Other Revenue	7,333
30. Total Revenue	3,485,181
31. General Services	584,495
32. Health Care	1,479,564
33. General Administration	705,466
34. Ownership	339,257
35. Special Cost Centers	104,298
35. Provider Participation Fee	67,528
37. Other	0
40. Total Expenses	3,280,608
41. Income Before Income Taxes	204,573
42. Income Taxes	0
43. Net Income or Loss for the Year	204,573
43.Other Long-Term Liabilities (specify):	0
44.Other Long-Term Liabilities (specify):	0
45.Total Long-Term Liabilities	3,443,337
46.Total Liabilities	4,102,981
47.Total Equity	419,054
48.Total Liabilities and Equity	4,522,035

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